



OUTREACH FORM

Case Action Log Supplement

CLIENT NAME: _____ DATE COMPLETED _____

Outreach Worker's Name: _____ Agency _____ Worker's Ph. # _____

LOCATION WHERE APPLICATION TAKEN: Home ☐ Office ☐ Other _____

APPLICANT'S IDENTITY VIEWED (circle one): ID (state) DL (driver license) Other _____

US CITIZENSHIP: Y N If no, what document did you view to prove legal residency? _____

SOCIAL SECURITY NUMBER (SS): verification(s) of all household members 18 or over (use back if more space needed)

Document Viewed (Award let, SS card, etc.)	Name as it appears on document	D.O.B. dd/mm/yyyy	SS # as it appears on the document

INCOME: Document income received the previous month for everyone, even if no income* is received

Month Used is: _____ (deductions also must match this same month)

Name of person	Income Source (name of employer)	Date Rec'd	Document Viewed *If an adult has no income, obtain an applicant statement or Deficit Statement from individual of how expenses are being met.	\$ Amount Must be <i>Gross</i>
			Total Income: (Use back page if more space needed)	

VERIFICATION OF CHILD UNDER 6 (DOCUMENTS VIEWED): Birth Certificate Blessing Certificate Other Viewed

VERIFICATION OF DISABILITY: Award letter ☐ Doctor's letter ☐ Other: _____

If disability is viewed, explain what was seen: _____ (use pg 2 for more info)

TOTAL MEDICAL EXPENSES PAID OUT IN THE MONTH OF _____ \$ _____ (Must Itemize on page 2)

CHILD SUPPORT PAID OUT IN THE MONTH OF _____ \$ _____ (Indicate on page 2)

Type of Residence: (CIRCLE 1) House Apartment (3 or more residences) Other: _____

Main Heating Source: (CIRCLE 1) Gas Electric Propane Oil Wood Other _____

If taking **Actual Amount** for utilities, please complete:

Gas/heat source \$ _____ + Electric \$ _____ for month of _____ = TOTAL \$ _____

Utilities included in Rent? Y N (if yes, submit a **Landlord Statement** with application)

PAYMENT TO (indicate the percent 50, 75, or 100%, the client wants payment to be made):

1 Name of Utility	%	2 Name of 2nd Utility	%
Account #:		Account #:	
NAME on bill if different & why:		NAME on bill if different & why:	

OUTREACH FORM Case Action Log Supplement, Page 2

MEDICAL/ DENTAL DEDUCTIONS:

Month Used is:

(Must match month income was used.)

Date of payment	What proof of payment did you view? (store receipt, hospital statement, bank statement, canceled check, pharmacy printout, etc..)	What is medical payment for? (Prescriptions, medical insurance, co-pay, eyeglasses, dental visit, etc.)	Amount Paid

Total Medical Expenses Paid

\$

CHILD SUPPORT and/or ALIMONY DEDUCTIONS:

Date of payment	What proof of payment did you view? (Canceled check, check stub, letter from ex-partner, etc.)	Amount Paid

Total Child Support and/or Alimony Paid

\$

CASE NOTES Use this area to provide any other information pertaining to this case.
